MassHealth

Certification for Payable Abortion

Invoice #: _____

Provider #: _____

This form must be completed and kept in the member's medical record. Please print.

Name of Patient:

_____

Address of Patient:

_____

Date of Abortion Procedure:

_____

Name and City of Facility in Which Abortion Procedure Was Performed:

_____

Check the appropriate box below to indicate which of the following four circumstances is applicable and complete that section of the form only.

(1) ☐ Life of the Mother Would Be Endangered

I, _____, certify that on the basis of my professional
(Print name of attending physician.)
judgment, the life of the above-named patient would be endangered if her pregnancy were carried to term.

_____
(signature of attending physician) (date)

(2) ☐ Severe and Long-Lasting Damage to Mother's Physical Health

Complete both A and B below. Certification by two physicians is required.

A. I, _____, certify that on the basis of my professional
(Print name of attending physician.)
judgment, severe and long-lasting physical damage to the above-named patient would result if her pregnancy were carried to term.

_____
(signature of attending physician) (date)

B. I, _____, certify that on the basis of my professional
(Print name of consulting physician.)
judgment, severe and long-lasting physical damage to the above-named patient would result if her pregnancy were carried to term. I also certify that I am not an "interested physician."*

_____
(signature of consulting physician) (date)

(3) ☐ Victim of Rape or Incest

Complete either A or B below.

A. I, _____, of the _____
(Print name of agency authority.) (Print name of law enforcement or public health agency.)
received a signed report from _____
(Print name of person reporting incident.)
of _____
(address)
stating that the above-named patient was the victim of an incident of rape (or incest) that occurred on _____. The report was made on _____, which
(date of incident) (date of report)
was within 60 days of the date on which the incident occurred.

_____
(signature of law enforcement or public health agency authority) (date)

B. ☐ Certification from a law enforcement or public health agency containing the above information is attached on a separate sheet.

(4) ☐ Other Medically Necessary Abortion

I, _____, certify that on the basis of my medical
(Print name of attending physician.)
judgment, for reasons other than those described in (1), (2), or (3) above, the abortion performed for the above-named patient was necessary in light of all factors affecting her health.

_____
(signature of attending physician) (date)

*Note: An "interested physician" is one: (a) whose income is directly or indirectly affected by the fee paid for the performance of the abortion; or (b) who is the spouse of, or another relative who lives with, a physician whose income is directly or indirectly affected by the fee paid for the performance of the abortion.